

MSSVD

Report of the Honorary Secretary to the 79th annual meeting of MSSVD held at the Royal Society of Medicine, Friday 27 October 2000

My final year as Honorary Secretary to MSSVD is now drawing to a close. The final challenge I set myself is to have circulated a summary of the main activities of the society including accounts and financial report in advance of the annual general meeting. It has required the hard work of the officers of the society, the secretariat and finance department at the RSM, and Graham Tomlinson, charitable governance adviser. The annual report was printed in November and circulated to members.

There are now 657 UK members of the society, with 101 overseas members and 31 honorary life members, 21 of whom are resident in the United Kingdom. There were 62 new members last year, of which 34 were nurses and health advisers. There are a number of MSSVD members to whom we paid tribute. These included Dr Ratnatunga; Dr Seaman; Dr George Csonka; Dr Christine Bakshi; Dr T Reed; Dr Andrew Crooks.

January 21 was a particularly sad occasion for the society when Maggie Godley sadly died following her two year illness. She will be remembered for all the work she put into running both MSSVD and AGUM and for her care and support as a fellow human being. Her husband has agreed to a memorial, which will be in the form of a prize given to the best presentation from a district general hospital consultant at MSSVD Spring meetings.

The past year has seen an even more rapid pace of change resulting in the Honorary Secretary having difficulty keeping her head above water. Some major issues for the society have been identified.

The first of these is a review and implementation of the changes to the charitable governance of MSSVD. As incoming treasurer, Simon Barton investigated the duties and role of the Honorary Treasurer and after discussion with the officers, it was agreed that expert assistance would be required to undertake a comprehensive review of the society's position. Mr Graham Tomlinson was appointed as an external consultant to support the officers, resulting in the clarification of the roles and responsibilities of the officers, council, and trustees of the charity. Clearer mechanisms for decision making, strategy, and development of business plans are in place for the future. The charitable governance review will continue next year with his support. The Honorary Secretary and treasurer together with Mr Tomlinson have been developing an appropriate contract with the RSM to provide infrastructure and support services for the running of the society and refinement of the membership database. The contract will include a specification for secretarial and financial services, lines of accountability, an arrangement with the society for housing and lending of the MSSVD library books, and support for educational activities.

Educational initiatives

The Education Sub-Committee met on five occasions. Following discussion at the Education Sub-Committee, it was agreed that in 2000-1, one of the ordinary general meetings' format would be altered to take into account adult learning theory; the meeting will be in March 2001 and run by the HPV Special Interest Group. The "Induction training steering group" has achieved its objective of producing an educational package suitable for non-consultant career grade doctors starting in the specialty and this will be launched at the start of this academic year. A skills course "Teaching the teachers" has been developed by the education officer Dr Jonathan Cartledge and education coordinator Sarah Chippindale, which will take place in November. Dr Jonathan Cartledge has completed his term of office as education officer and relinquished his post in December 2000. Sarah Chippindale was coopted from her post as academic health adviser at Mortimer Market Centre and returned to her full time post in December 2000. On behalf of MSSVD members, I would like to thank them for challenging the education subcommittee with new ideas and engendering a critical look at our education and meeting programme. The future of further educational initiatives and support structures required to deliver these will be a priority for this coming year.

The website has become an integral part of delivery of education to members of MSSVD. The OGM meetings are now summarised and reported on the website. This initiative will be developed in the future as information technology at the RSM changes. There may be an opportunity to provide more webcasting similar to that undertaken at the MSSVD Spring meeting, in Baltimore.

CME/CPD

A major change for doctors over the next 2 years will be the introduction of revalidation. The royal colleges have been working together with the GMC to coordinate the requirements for revalidation. The Royal College of Physicians has formalised a CME/CPD committee following meetings between CME regional representatives and specialist societies. CME/CPD requirements will change and some assessment measures will be introduced. All doctors will be required to undertake CME/CPD and this will have substantial effects on clinics employing NCCG colleagues. MSSVD as a specialist society will be devising appropriate CME for its members in liaison with the RCP.

Meetings

Five ordinary general meetings were held in the Barnes Hall at the Royal Society of Medicine. The topics highlighted important advances in diagnosis and management. There were key strategic issues for the specialty raised particularly in relation to medicolegal aspects and the needs of adolescents. The "Doctors in training" presentation meeting, which gives opportunity for practising presentation skills, showed that our trainees continued to perform to a high standard. The prize was awarded to Dr Nelson David, for his presentation on "Zoon's balanitis."

MSSVD was host society for the Federation of Infection society meeting held in Manchester on 1-3 December 1999. This is the first time that the meeting has coincided with the World AIDS day. The meeting was very successful with the highest number of

registrants recorded. Consequently, the VAT bill was larger than usual and the term "success" was confined to educational and social rather than financial! The debate trio of Drs Simon Barton, Colm O'Mahony, and Dolores Hooker provided eye opening entertainment for our more reserved colleagues in other infection disciplines.

MSSVD continues to provide meetings in conjunction with other societies. These have included the SSSTDA/IUSTI meeting held in Sun City, South Africa, and the joint BHIVA/MSSVD held on 8 October 1999. The MSSVD/ASTDA inaugural meeting was a resounding success. The society has been asked by the Section of Dermatology at the RSM to develop a joint meeting, which will take place on 8 June 2001.

NCCG meeting

The MSSVD NCCG meeting organised by Dr Jonathan Ross took place in September and was well received.

MSSVD National Continuing Professional Development course in GU Medicine/HIV/AIDS

This year the MSSVD took over the running of the course, previously known as BPFM, latterly the CPD course run by University College, London. The steering group is chaired by Dr Jackie Sherrard. This is a new and challenging venture for the society. The aim will be to offer a reduced price for MSSVD members on courses arranged by MSSVD. There has also been discussion about the need for a more basic course directed at primary care physicians, healthcare workers working in contraceptive services, and others providing sexual health services to complement the DFFP run by the Faculty of Family Planning and Reproductive Health Care (FFPRHC). Over the next year a core curriculum will be developed and the course piloted. The intention is to deliver this on a regional basis.

Special interest groups

The six special interest groups have submitted business plans to the treasurer for their educational activities for 2000-1. A proposal for a further special interest group of "Adolescent sexual health" has been accepted by council and will be submitting a business plan.

Doctors in training meeting

Last year the meeting was held in the president's home city of Sheffield. Although the standard of hotels fell short of expectations, the scientific programme was well received and the skill workshops of personal image and communication skills provided direction to the consultants of tomorrow. The local cabaret of Karen Rogstad, David Daniels, Mary Stevenson, and Stephen Green, infectious disease consultant at Sheffield, entertained us on Saturday evening. Pfizer kindly sponsored the event.

MSSVD undergraduate prize

This was awarded as follows: clinical prize to Dr Daniel Jary, "Why do young people still catch STDs?"

Other MSSVD activities

The changes in provision of medical care driven by government have made a significant impact on the day to day activities of all healthcare workers. Key issues that have been discussed at council have included charitable

governance, funding of sexual health services, BMA AIDS foundation, "Access to clinics" report for CMO, liaison with FFPRHC, and reciprocal CME.

The Sexual Health and HIV Strategy due to report in early 2001 may have a significant impact on services providing sexual health care. The challenge for our specialty is to be at the forefront of these changes, being part of the broader picture and outward looking into the communities which we serve, in contrast to a more passive approach of waiting for the "at-risk" population to come to us. This requires a critical look at the way services are provided at present and opportunities for providing them in a more efficient way. Our strengths, particularly with regard to health promotion, partner notification, accessibility and skills in communicating with young people, need to be increased and marketed. We are fortunate to have at the helm of MSSVD an extremely proactive president with strategic vision and a grip on operational aspects of running sexual health services. I am delighted that the work which has been undertaken over the 4 years since I have been Honorary Secretary will continue, be refined, and changed according to political imperatives and the needs of people accessing our services. I wish Keith Radcliffe as my successor good fortune and thank him and the treasurer and president for all the help and encouragement that they have proffered over the last year.

Finally, my thanks to all fellows and members for their continuing support to the MSSVD and to me personally over these past 4 years.

ANGELA J ROBINSON
Honorary Secretary

LETTERS TO THE EDITOR

Papulonecrotic tuberculide of the glans penis

EDITOR,—A 27 year old promiscuous, married man presented with recurrent episodes of ulceration of the penis of 12 years' duration. Each episode began with a painful small raised lesion which got ulcerated and finally healed spontaneously in 2–3 months. The present episode of painful ulceration had been lasting for 6 months or so. In spite of various treatments received from various private practitioners, his genital sore did not respond.

On physical examination, this moderately nourished individual had a single well defined ulcer on the glans penis near the urethral meatus, measuring 8 × 5 mm. The edge of the ulcer was undermined and its floor had necrotic slough. The ulcer had perforated deeply into the urethra, resulting in dribbling of urine through it (fig 1). Multiple puckered scars over the glans penis circumferentially, just distal to the coronal sulcus, were evidence of previous episodes of similar ulcerations. The inguinal lymph nodes were not significantly enlarged. His systemic examination was unremarkable.



Figure 1 Glans penis showing both ulcer and puckered scarring.

The haemogram revealed a raised erythrocyte sedimentation rate (64 mm in the first hour). The Mantoux test was strongly positive (20 × 20 mm). VDRL and HIV serology was non-reactive. Radiological investigations did not demonstrate any focus of tuberculosis in the chest or genitourinary system. Smear and culture of discharge from the ulcer and also of urine for acid fast bacilli were negative. Histopathological examination of the ulcer (glans penis) revealed ulcerated epidermis. In the deep dermis, by the side of the ulceration, there were caseating tuberculous granulomas along with perivascular inflammatory infiltrate with vessel wall thickening and endothelial cells swelling. Fite's stain for acid fast bacilli was negative. These features were consistent with the diagnosis of papulonecrotic tuberculide. The patient was treated with a four drug regimen for antituberculous therapy to which he responded favourably. At the end of 2 months, the ulcer had healed completely.

Even though it is considered to be rare, tuberculosis of the penis may manifest as primary, secondary, or papulonecrotic tuberculide type.^{1–4} Clinically, it may present as superficial ulcers of the penis or tuberculous cavernositis.² Papulonecrotic tuberculide, a form of cutaneous tuberculosis, represents an allergic reaction to bursts of antigens reaching highly immune skin following haematogenous spread from an internal focus. The tuberculous focus is often not clinically active at the time of eruption⁵ as seen in our case. The diagnosis of papulonecrotic tuberculide in our case was based on the well laid down criteria.^{3,4}

Papulonecrotic tuberculides are mostly extragenital, but rarely genitalia may be involved.³ Sometimes, the glans penis alone may be involved as in our patient and then diagnosis becomes difficult. Under these circumstances, it needs to be differentiated from atypical soft sore, syphilis, recurrent herpes simplex, and malignant ulcer.⁴ The diagnosis of such cases rests on biopsy, tuberculin testing and, in doubtful cases, a therapeutic test is usually decisive.^{1–4} The possibility of tuberculosis as a cause of chronic ulcer on the penis has to be kept in mind especially in countries like India, where tuberculosis is still prevalent.

Table 1 Mean total and subscale scores for Attitudes to Lesbian and Gay Men (ATLG) Questionnaire

	Male (n=86)	Female (n=123)	p Value
ATLG mean (range)	69.0 (20–176)	56.0 (20–142)	0.003
ATG* mean (range)	40.9 (10–90)	31.8 (10–62)	<0.001
ATL† mean (range)	28.4 (10–90)	24.2 (10–80)	0.03

*ATG = Attitudes to Gay Men.

†ATL = Attitudes to Lesbians.

Contributors: MV wrote the manuscript; DMT was involved in planning and execution of the manuscript; PKK took part in the management of the case and literature search

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Attitudes to lesbians and homosexual men: medical students care

EDITOR,—We read with interest the article by Fethers and colleagues on STIs and risk behaviours in women who have sex with women (WSW) and the accompanying editorial by Marrazzo.^{1,2} It is gratifying to see our own results³ replicated in a larger and more complete study. Marrazzo highlights many of the methodological difficulties and deficiencies in research into WSW and comments specifically on "lack of interest" or homophobia contributing to the paucity of interest into STI risk among WSWs. Homophobia is recognised as a barrier to accessing health care.⁴ We wish to report encouraging attitudes among the majority of medical students but forewarn colleagues of the potential for difficulties with attitudes in a minority of medical students.

Over the past 3 years we have administered the "Attitudes to lesbians and gay men" questionnaire⁵ to final year medical students at St Bartholomew's and the London Medical School as part of core teaching on "sexuality and sexual health," in order to promote discussion. This consists of two 10 item subscales for assessing heterosexual attitudes to homosexual men and lesbians. The 20 statements are presented in Likert format with a nine point scale ranging from "strongly disagree" to "strongly agree," therefore scores range from 20 (extremely positive attitudes) to 180 (extremely negative attitudes). We have analysed the responses to 217 questionnaires: 41% of the sample were male and the median age was 23 (range 21–34 years). The